

Family Intervention in the Problem of Maternal Death: A Case Study of Pregnant Women in Mbojo, Bima, West Nusa Tenggara

Atik Triratnawati; Anis Izdiha

Universitas Gadjah Mada, Indonesia

Corresponding Author: atik_triratnawati@yahoo.co.id

ABSTRACT

In 2015, the maternal mortality rate in Bima was recorded as 3 cases per 1,000 births, equivalent to 300 maternal deaths per 100,000 births. Although this number is low, it is much higher than the zero mortality rate set by the Sustainable Development Goals. This study discusses the family and community aspects of the maternal health framework, reading the gendered symbolic violence that affect maternal health in Jatibaru Village, Asakota, Bima, West Nusa Tenggara. Data was collected using an ethnographic approach, with techniques including Focus Group Discussions, participatory observation, interviews, and document study. The existence of gender inequities in the family can cause problems when women attempt to access healthcare. Furthermore, families and communities exert control over pregnant women, directing their behavior and attempts to access healthcare according to local customs and traditions. As such attitudes and behaviors are part of the digestive process of knowledge and experience, women often accept and do what is recommended by their families and communities. This social reality of maternal health thus becomes part of gender inequality in society.

Keywords: *mortality rate; family intervention; gender inequality; Mbojo; Bima*

INTRODUCTION

Gender and health issues have become increasingly commonly discussed since the World Population and Development Conference (ICPD), held in Cairo in 1994, initiated public discourse on women's reproductive rights. This conference was followed by the Beijing Conference of 1995, which discussed indigenous peoples (Purwaningsih, 2002). In 2002, the World Health Organization developed a gender analysis framework within the field of health and healthcare (WHO, 2003). Biologically, women and men are different. Women's bodies have more complex organs than those of men, and owing to these biological differences women's reproductive functions health requires gender-based medical services (WHO, 2004).

Gender identity begins to develop in babies

as they interact with certain people (mothers, fathers, and caregivers). The way these adults interact is influenced unconsciously by prevailing stereotypes (Sadli, 2010). Children's socialization of their gender identity begins within the family, and develops into behavioral tendencies that distinguish men and women. These behavioral differences lead to men and women to be positioned differently within religious and social contexts, with women being treated differently within their households, communities, or even countries (Nugroho, 2011).

Similarly, many factors influence women's reproductive health. For example, in the family, husbands have full authority over financial arrangements as well as food, drug, and health care selection in rural Guetamala (Charter, 2004). In India,

mothers-in-law interfere in young couples' selection of contraception (Char et al, 2010). Pregnant women who live with husbands, meanwhile, have no more preference for adequate health services than women who foster good relationships with their in-laws (Allendorf, 2010). Family structure, thus, determines the health of children (and women) in the family (Heard et al., 2008)

Family structures that put women in a position of inadequate bargaining power leads to them experiencing cultural and social dominance in society. Bourdieu (2001) uses the terms symbolic violence, symbolic power, and symbolic dominance to refer to the process through which class structure informs social formation, including (in the context of this paper) the family. Bourdieu defines the above-mentioned concepts as the power to determine the instruments of knowledge and arbitrary expression of reality.

Social order is part of the symbolic machines intended to strengthen masculine dominance. Social constructs thus present the dominant relations between structures and shapes gendered concepts of vision and division. The female body becomes only a justification of social status (Irwanto, 2006). This study discusses the family and community aspects of gendered symbolic violence that affect maternal health in Jatibaru Village, Asakota, Bima, West Nusa Tenggara.

West Nusa Tenggara has a fluctuating Maternal Mortality Rate (MMR). Over the past ten years, it has had difficulty reducing its maternal mortality rates. In 2009, this rate saw a substantial increase, rising from 92 cases of maternal death in 2008 to 121 cases. In subsequent years, reported maternal deaths have never been fewer than 100 cases—even after the Government of West Nusa Tenggara implemented its AKINO (Zero MMR) program in 2011.

Maternal Mortality in West Nusa Tenggara is distributed evenly among districts and cities. Data on cases of maternal mortality in 2014 includes information on deaths per region. The highest maternal mortality rates in the region are found in East Lombok. However, the city of Bima is more densely populated, with a population density of 727 inhabitants per km², higher than East Lombok (population density: 711 inhabitants per km²) (Health Profile of the West Nusa Tenggara Provincial Health Office). The gender ratio in Bima also shows a greater proportion of women to men; the city is home to 76,922 women and 74,032 men.

Table 1. Maternal Mortality in West Nusa Tenggara, 2005–2014

| Year | Cases |
|------|-------|
| 2005 | 108 |
| 2006 | 97 |
| 2007 | 95 |
| 2008 | 92 |
| 2009 | 121 |
| 2010 | 113 |
| 2011 | 130 |
| 2012 | 100 |
| 2013 | 117 |
| 2014 | 111 |

Source: Health Profile of West Nusa Tenggara (2005–2015), Provincial Health Office of West Nusa Tenggara

In 2015, three cases of maternal mortality were recorded in the city of Bima (Bima in Figures, 2015). In addition, Bima is interesting to study because of its geographical and cultural context. Bima covers a geographic area of about 222.25 km². The city has two hospitals, five health centers, and village health posts (one in each village) that provides antenatal and childbirth services. Medical personnel are also present in all villages, with an average of 8–9 midwives and also supported by the presence of clinical midwives and obstetricians. Bima also has KJS (Kartu Jujur Sehati) cards that guarantee free medical care for those bringing their ID cards. Residents of Bima also participate in the BPJS, Jamkesmas, and Jamkesda programs. Culturally, the people of Bima are tightly bound by taboos regarding pregnancy and death, which are presented in a variety of restrictions for pregnant women.

This study examines how aspects of gender inequality present in society bias the decision-making behavior related to healthcare for pregnant women. This study focuses on unequal social structures within the family that may influence pregnant women, wives, and children, and force them to endure lower standards of living than men. Furthermore, this study examines whether unequal gendered structures are the reason for women's poor access to health services, and how families exert control over the health of pregnant and lactating mothers.

Using an ethnographic approach, this study

examines the case of Jatibaru Village, Bima, this study was conducted between April and August 2016. Informants from this study were ten women who had experienced childbirth and breastfeeding and were thus expected to have an understanding of how decisions about their maternal health were made during their pregnancy and after the birth. These informants were thus the key analytical units. Informants in this study were predominantly between the ages of 18 and 35, the fertile age for women. Informants generally had a secondary or senior high school level of education. Those informants in the workforce worked as brickmakers or farmers. Their husbands, meanwhile, worked as motorcycle taxi drivers, masons carpenters, and construction laborers.

In terms of family structure, some informants lived alone with their husbands, some lived with their in-laws or with their mothers. Some informants were in mixed marriages; one informant came from Makassar, with her husband being from Bima, while another female informant came from Bima (Jatibaru Village) and had a Javanese husband. Such differences in informant categories were intended to gather different knowledge and experiences related to the issue of family health.

This study uses both primary and secondary data. Primary data were collected through focus group discussions, in-depth interviews, observation, and documentation, while secondary data were collected from statistical reports and relevant references. Initial data were collected through focus group discussions (Irwanto, 2006) to obtain local knowledge about pregnancy and death in Jatibaru Village. Participant observation was thus done, with the researcher participating in the community where the informants live during the research process. Observations were made using a personal approach with informants, observing their daily activities, and observing the social, cultural, and economic environment of Jatibaru. Participant observation produced a description of the social, cultural and economic circumstances experienced by informants, which inform their actions as they handle pregnancy.

In-depth interviews using unstructured interview guides were conducted to learn about eight subject categories: economy, formal education, sex education, work activity, family environment, pregnancy experience, cultural activity, and health seeking behavior. The researchers conducted three interviews with each informant to ensure data clarification and data addition. Informants tended

to recall additional information in more intense meetings or during second or third interviews. Repeated meetings also provided a sense of personal closeness between researchers and informants. Documentation studies were conducted by collecting data on population registration as well through library research. In collecting monographic documents, researchers coordinated and communicated with the village administration, i.e. those formally responsible for providing village health facilities.

All data were analyzed using an interactive model proposed by Milles and Huberman (1992), who identified three steps of data analysis: data reduction, data presentation, and conclusion and verification. As a result of data reduction, field record data will be sorted according to the needs of data discussion. Data are presented in a context intensive discussion, with critical analysis presented in sub-sections of this paper. This paper thus describes gender inequality within the context of maternal death in Bima.

FINDING AND DISCUSSION

Contributions of Religion and Tradition to Gendered Symbolic Violence

The village of Jatibaru, part of Bima City, consider themselves part of the “Mbojo Tribe” that characterizes the people of Bima. An Islamic cultural and religious framework still underpins the understanding of women’s positions within the family in Bima. According to Bima tradition, married women and men are bathed with flower water by a traditional leader or elder (such as a *sando*) as a symbol of self-cleansing for past errors and starting a new life. This is also meant as a binding commitment between the bride and groom and prevent extramarital affairs. Women are culturally bound by this bath to be faithful to their husbands.

When a wife has gone through the first phase of pregnancy, a pregnancy ritual is initiated. In Bima custom, after known to be pregnant, women will perform a congregational bathing ritual with the aim of cleansing themselves and ensuring a smooth pregnancy. This tradition will be led by a *sando* (shaman). These rituals are performed at different intensities, depending on the demands of the pregnant mother or her family; generally, such congregational baths may be held once a month, once a week, or even once a day. In the fifth month of pregnancy, there is also the tradition of *Pe’eloko* or massage for pregnant women, performed once a week, once a

month, or when pain is felt. This is intended to change the position of the baby in the womb, with the head pointed down.

The people of Bima believe that an easy pregnancy begins with the baby being in the correct position. For a mother's first pregnancy, there is the traditional *kiriloko* ceremony, held in the seventh month. This ceremony is intended as a form of prayer, asking for a smooth pregnancy and childbirth. After the child is born, *zakat fitrah* (alms) should be given to the *sando* for three consecutive years; this is intended not only to ensure that the child becomes a helpful member of the family, but to maintain a cultural relationship with the *sando*.

After the child is born into the world, there are the traditions of *capisari* and *akikah*. The former is a thanksgiving or *slametan* ceremony, corresponding with the cutting off of the child's umbilical cord. Meanwhile, the latter involves the slaughter of one or two goats and is advocated in Islam as an expression of gratitude for the child's birth. It also involves the child's first haircut and the child receiving a name. Among families with sufficient economic capacity, the *capisari* ritual is generally followed by the *akikah* ritual.

Bima tradition recognizes certain medicines and scrubs for pregnant women and childbirth. Generally, pregnant women in Bima traditionally consume coconut water in the seventh, eighth, and ninth months of pregnancy, consume *kencur* (bitter ginger) to in the seventh and eighth months, and drink *Loi Paipiri* ("bitter medicine") in the seventh, eighth, and ninth months. Coconut water is intended to ensure a clean birth, while *kencur* and *Loi Paipiri* are intended to eliminate any odors and stem blood loss. The people of Bima refer to *Loi Paipiri* as a "medicine" because, according to their knowledge, it cannot be categorized as a herb or spice.

They also have drugs known as *Loi Pakombu* and *Loinata*. The former is a bitter remedy consisting of turmeric, ginger, temulawak, cloves, acid wood, pomegranates, wood suntu, and kadara. All of these ingredients are soaked in warm water, squeezed, and then filtered. *Loi Pakombu* is drunk by new mothers twice a day, before bathing, in the morning and in the afternoon. After bathing, they will apply *Loinata*, which consists of ginger, palam garlic, pepper, cloves, *sabia*, *musi*, and some rice that has been soaked in water. This *Loinata* is intended to provide a sense of warmth, and thus it must be applied to the entire body. *Loinata* is believed to relieve various afflictions,

including exhaustion and postpartum pain. According to mothers, using *Loinata* after giving birth enables them to recover quickly, and thus return to their activities. *Loinata* is used for one or two months after delivery.

Limited Access to Maternal Healthcare

In regards to their knowledge about the roles of wives and husbands in the family, all informants had the same tendencies in their answers: a wife must be able to help her husband and obey her husband and his parents. Despite their different educational and economic statuses, eight informants described submissiveness and obedience as part of their knowledge of the customs of Bima and of their Islamic religion. They may help their husbands by, for example, taking care of the household and children. This may also be interpreted as meaning helping the family business such as baking bricks or helping in the fields, or by seeking additional income.

"In Jaribaru 3 Hamlet, a wife works harder than her husband. A good wife is a wife who can make money to support the family finances. In the morning, a wife will do household activities: preparing breakfast for their husbands and children, helping prepare the children for school, cleaning the house, and raising the new children after that they will work to their neighbors for brick molding. In the summer, the wife will work in the morning or afternoon and entrust her children to her mother, mother-in-law and neighbors" (Breastfeeding Mother, 3)

Wives' obedience is also demonstrated by their fear of their husbands' wrath. There is a view that, if a wife does not obey her husband, bad things will happen to them. Especially among housewives, decisions not made with their husbands are believed to damage their marriage. Every decision in the household will be discussed, except those related to the kitchen and children.

In maternal health care, obeisance is seen in women's "compliance" wherever a pregnant woman experiences a pregnancy disorder. Although public health insurance enables them to receive free treatment, most women still consult with *sando* (shamans). For one treatment, patients will be asked to pay about Rp 10.000–20.000; payment may also take the form of a pack of cigarettes or groceries.

Members of the community are accustomed to

using the services of *sando* because they are available 24 hours a day, meaning there is no fixed time limit. If a *sando* is not serving another patient, the *sando* can be picked up at home or visited at any time. Mrs. Sw told about how her husband, mother-in-law, and mother advised her to frequently receive stomach massages from the *sando*.

“My husband said, if I feel sick, I should quickly check with the *sando*. In addition, I also made time with the *sando*, tried to remember how to receive support through massages” (Sw, Housewife).

In addition, there are also mothers who, on the advice of their husbands and families, give birth with a *sando*. Meanwhile, unlike mothers who live with their in-laws and husbands, mothers who live alone with their husbands are more selective about what their mothers-in-law and husbands say. If a woman’s mother-in-law says to go to a *sando*, but her husband does not require it, she will not go. Prohibitions against meeting midwives are not unilaterally accepted by mothers. If a mother feels the need to meet a *sando*, she will do so. Sometimes husbands will take their wives to the *sando*. Mothers will comply, as their husbands have made an effort to transport them. Women may also be taken to the *sando* by their in-laws, when their husbands are busy working.

It is not uncommon for in-laws, husbands, and mothers to have different knowledge about pregnancy. Husbands will generally use their mothers’ as reference for maternal care; this often results in them relying on *sando*. When *sando* cannot provide the necessary maternal care, husbands will then take their wives to village health post or the local health center. It is thus not uncommon for pregnant women in Jatibaru to receive two different types of treatment, i.e. from midwives and from *sando*. Village health posts function primarily to provide pregnant women with vitamins. As a result, ante-natal care is often lacking when pregnant women are not reminded to check with a midwife, but rather told to visit a *sando*.

Again, it is not uncommon for knowledge differences to exist between in-laws, husbands, and mothers. Husbands will refer to their in-laws for issues of maternal health care. When a wife experiences pain, she will first be taken to the *sando*. Only if a *sando* cannot handle the problem will husbands take their wives to the village health post or health center. It is therefore not uncommon for a pregnant

mother in Bima to receive two categories of treatment during their pregnancy. In pregnancy, mothers will sometimes receive treatment from the midwives at the village health posts. However, in the classes for new mothers held by midwives, husbands are often absent. When this occurs, pregnant women receive little information on the importance of medical health facilities. Ultimately, these posts function primarily to provide vitamins to pregnant women. As a result, women tend to receive poor ante-natal care when nobody reminds them to go to the village post.

Table 2 Decision-making and family-determined health access

| Subject Treatment | Advisor N= 10 | | | |
|------------------------------|---------------|----------|---------------|----------|
| | Husband | Mother | Mother-in-Law | Midwife |
| Medical (doctor, midwife) | | 1 person | 1 person | 6 people |
| Non-Medical (<i>Sando</i>) | 3 people | 3 people | 4 people | |
| Medical and Non-Medical | | 3 people | 3 people | 4 people |

Various assessments of health care forms are given by family members. They have preferences for certain health services, based on the functions being created. Seven referral health facilities can be accessed by a pregnant woman, but there is often overlap and distinctions in their functions. These different functions affect the decision making process for pregnant women. Going to a *sando* serves a different function than going to a midwife, but some pregnant women consider them the same.

Health Service Preferences for Pregnant Women in Jatibaru Village

Through the advice they receive from their families, women become familiar with healthcare preferences and their functions. Fifteen informants said that, in the first four months of pregnancy, they experienced mild or severe nausea and used the facilities at the village health post or an obstetrician. This stems from knowledge (of the pregnant women, husbands, parents, or in-laws) that *sando* are unable to treat this nausea.

Around the fifth month of pregnancy, pregnant

women will begin preparing for the customary rituals described above: the *loi*, *pe'eloko*, and *kiriloko* rituals in the seventh month, as well the consumption of *kencur* and coconut water, and use of *Loinata*. Bima rituals are known by families and neighbors.

Pregnant women are unable to deny the existence of these customary processions. All informants said they had conducted the *pe'eloko* ritual, bathed congregationally, and consumed traditional medicines. Informants claim that social consequences lead them to obey. The first of these is from the family; Mrs. At tells of how she decided to obey her husband when he took her to the *sando* for *pe'eloko*, for if she did not her family would be upset. The influence of the family was also felt by Mrs. S. The *sando* and the customary pregnancy rituals were provided by her family, and Mrs. S's could not because she lived with her in-laws. The possibility that her socio-economic life would become difficult without the aid of her in-laws led to her deciding to perform the ritual. Husbands are also involved. Mrs. NN said that, when she was not willing to apply *Loinata*, her husband stepped in and expressed some anger.

“I didn't feel like using *loinata*, because of the smell and the heat, but my husband often asked me after I bathed, ‘Eeeeh, why are you not using *Loinata*?!, So I did as my husband said” (Nn, Housewife)

Social consequences may also come from neighbors. When a pregnant mother gives birth, her neighbors will also remind her of the ritual processes that must be done. They may even use the threat that a child will become crazy to ensure that women keep performing these rituals, even when they are not financially able to do so.

“I often hear the question, *nggomiwati bade pe'eloko?* (Did you ever *pe'eloko*?). ‘If I do not do *Capisari*, my neighbors will be angry and ask questions. According to the people here, if a baby does not undergo the *capisari* ritual, she may go crazy someday” (Nh, Housewife)

The above mental threats may be followed by physical threats against women who do not perform the rituals.

“I gave birth with my mother's help, after three days I was doing my housework. Cooking, washing, sweeping... who would do everything if not me. I used *Loinata* so I could be fit” (Sw,

Bricklayer)

Kinship networks also support the establishment of social control for pregnant women. Pregnant women will receive many recommendations to come to the *sando*. Despite awareness that *sando* cannot help with labor anymore, many rituals require a *sando*. These *sando* may be their own relatives, including their mothers-in-law or grandmothers. Inevitably, pregnant women will visit relatives as well as *sando*, who will not charge them money because they are family and who offer them separate reasons to go to *sando*.

Among the informants were a husband and wife; the former came from Java and the latter came from Jatibaru Village. The wife had lived in Java, where she did not perform various customary rituals for her first pregnancy. She thus felt that the customs of Bima were not so necessary, and so she only used the services of a midwife and said a prayer of salvation.

“I am married to a man from Banyumas, and I lived in Karawang. I did not receive an abdominal massage (*pe'eloko*), because in my opinion it was not needed. When I was sick, I checked with a midwife, I also did not do the seven month tradition (*kiriloko*), but just a small prayer session. My husband said, “We must have a small prayer session to ask for salvation for the baby”. (Jh, Housewife).

However, because the family returned to Bima after the second child was born, the informant experienced her third pregnancy in the city. Mrs. Jh was often visited by her relatives, including her aunts, mother, and neighbors “*nggomiwati bade mandijemaah*”. She would be asked every day, “Do you never bathe?”, during the fifth month of her pregnancy.

“My aunt came to my house every day to force me to take part in congregational baths, because she happens to be an *ama-ama* (shaman) in Bima, I repeatedly refused it, gently, but when I was shopping, I was approached by my aunt, who invited me to shower for free. I finally followed the advice of my aunt and took a congregational bath. I was also asked by my neighbors why I did not do the *capisari*. My husband told me not to do the *capisari* ritual, but only the *akikah*. However, because my mother kept asking me, finally I

did the *capisari* together with the *akikah*” (Jh, Housewife).

Customary law applies to everyone with ties to the Mbojo tribe who lives in the area. Being in a mixed marriage does not enable a woman to ignore customary rules about pregnancy and childbirth. Customary law is positioned as something that must be done for the safety of the mother and baby. They are expected to adhere to the desires of their families and their indigenous communities.

High Risk of Gender Inequality in Maternal Health

Given their family roles, the quality of healthcare received by wives and pregnant women cannot be ignored. In Bima, a wife remains part of the social environment and bound by social rules. Similarly, in accessing healthcare, pregnant women are bound by how their family responds to their complaints. Husbands have an important role in influencing how pregnant women access health services; in line with the ideology of patriarchy, they (as men) exert the greatest dominance in the family (Nugroho, 2012).

Wives' expected obeisance is not limited solely to their husbands, but also their mothers and in-laws; as such, pregnant women are expected to do as they say, to follow their prohibitions and advice during pregnancy. A pregnant woman will do *pe'eloko* even when she does not really need it. Women are given inferior status within the cultural framework, expected to handle cooking, ironing, and other activities considered less than prominent by society (Irianto, 2015). Here, women's bodies have become an arena for practicing power, even though the body (as an individual's private property) should be a very 'private' and under the full control of the individual. As social control is exerted over this 'private world', women lose their freedom (Abdullah, 2006).

The unequal social structure affect pregnant women's personal attitudes regarding their own healthcare. The customary and religious framework embedded within traditional practice establishes social control over pregnancy itself. Dichotomous medical and non-medical health services are available for pregnant women, given their families' knowledge. In addition, knowledge of customs and religion also shapes the knowledge of pregnant women. One pregnant mother in Bima knew that *sando* were considered “good advice” about pregnancy. Every pregnant woman is expected to receive at least one

abdominal massage during every pregnancy from the *sando*, given their inferior position within the family.

Pregnant women in Bima are thus “initiated” within the family. They are encouraged to receive stomach massages from shamans (not midwives) as part of the power relations within their families. Pregnant women have little bargaining position within their families and communities. They come into contact with family and community structures before state structures. Gender inequality within the family thus affects how women access reproductive health services. Family and community perceptions direct how pregnant women access health services for themselves (Mckieet *al.*, 2004). As a result, pregnant women are often unaware of their own bodily disorders, and so there is no vigilance for detection or prevention (Burns, Lovich, R., Maxwell, J., et al., 2000).

Furthermore, the community environment establishes bastions of social control over pregnant women, coercing them into performing customary rituals that are seen as part of the traditions expected of pregnant women. In this case, pregnant women exist at the point of intersection between themselves and their communities. Social control spreads as a form of understanding of women in their environment. Pregnant women are unable to escape social control, and although this control may weaken when women leave the community, when women return to the community they will again be covered by these rules.

Women's healthcare has yet to guarantee their physical health. Ahimsa-Putra (2005) also describes physical health in individual and socio-cultural contexts. In this case, health does not only involve physical body elements, but results from a process of interaction between internal body elements and external elements. Ahimsa-Putra suggests that several external factors affect health: (a) psychological, (b) social, and (c) cultural. These factors, thus, may be considered external factors that affect one's health. Pregnant women in Bima, who still strictly follow the directions of their families, lack independence in their physical health management. Such family intervention indicates the application of power through action (Deacon, 2002). Stagnant access, binding control, and lack of participation indicate that women experience impoverishment both culturally and structurally (Mosse, 2003). Cultural factors play an important role in constructing the reality of women's health, including their own safety (Ayuningtyas, 2004).

CONCLUSION

In maternal health fulfillment, husbands, biological mothers, and mothers-in-law significantly influence how pregnant women access health services, both medical and non-medical. Cultural and religious constructs have positioned the women of Bima as wives who must obey their husbands and parents. This social reality affects how the provision of maternal healthcare is done. Custom processions for pregnant women thus become necessary as pregnant women are urged by their families.

This unbalanced social structure is accepted by women as knowledge and experience, leading to them taking an attitude of inferiority. Women make decisions about healthcare as a means of understanding their elections and based on subjective truths in their communities. This study also shows progress in maternal health outlook; by improving the health of pregnant women, families and communities can also be educated about pregnancy.

ACKNOWLEDGEMENTS

This research was funded as part of the Research Agenda at the Faculty of Cultural Sciences, Universitas Gadjah Mada. The author would like to express her gratitude to the dean and her staff. In addition, this paper was developed under the guidance of an advisor appointed by the faculty, Prof. Dr. Irwan Abdullah.

REFERENCES

- Abdullah, Irwan (2006). *Sangkan Paran Gender*. Yogyakarta: Pustaka Pelajar, Third Edition.
- Ahimsa-Putra, Heddy Shri (Ed.) (2005). *Masalah Kesehatan dalam Kajian Ilmu Sosial Budaya*. Yogyakarta: Kepel Press.
- Allendorf, Keera, (2010). The Quality of Family Relationships and Use of Maternal Healthcare Services in India. *Studies in Family Planning*, 41(4), 263–276.
- Ayuningtyas, D. (2014). *Kebijakan Kesehatan, Prinsip dan Praktik*. Jakarta: Raja Grafindo Persada.
- Bordieu, Pierre (2001). *Masculine Domination*. California: Stanford University Press.
- Burns, A.A., Lovich, R., Maxwell, J., et al. (2000). *Pemberdayaan Wanita dalam Bidang Kesehatan*. Yogyakarta: Yayasan Essentia Medica.
- Char, Arundhati et al. (2010). Influence of Mothers-in-Law on Young Couples' Family Planning Decisions in Rural India. *Reproductive Health Matters*, 18(35), 154–162.

- Charter, Marion W. (2004). Gender and Community Context: An Analysis of Husbands' Household Authority in Rural Guatemala. *Sociological Forum*, 19(4), 633–652.
- Deacon, Roger (2002). Truth, Power and Pedagogy: Michael Foucault on the Rise of Discipline. *Educational Philosophy and Theory*, 34(4), 435–458.
- Heard, Holly E. et al. (2008). Family Structure and Self-Rated Health in Adolescence and Young Adulthood. *Population Research and Policy Review*, 27(6), 773–797.
- Irianto, Koes (2015). *Kesehatan Reproduksi, Reproductive Health Teori dan Praktikum*. Bandung: Alfabeta.
- Irwanto (2006). *Focus Group Discussions (FGD)*. Jakarta: Yayasan Obor Indonesia.
- Mckie, Linda et al. (2004). Starting Well: Gender, Care and Health in the Family Context. *Sociology*, 38(3), 593–611.
- Miles, B. B. and A. M. Huberman (1992). *Analisis Data Kualitatif*. Jakarta: UI Press.
- Mosse, Julia Cleves (2003). *Gender dan Pembangunan*. Yogyakarta: Pustaka Pelajar and Rifka Annisa Women's Crisis Centre.
- Nugroho, Riant (2011). *Gender dan Strategi Pengarusutamaannya di Indonesia*. Yogyakarta: Pustaka Pelajar.
- Nugroho, Titus Febrianto Adi (2012). *Relasi Perempuan dan Laki-laki Sebuah Perspektif*. Yogyakarta: Impulse.
- Purwangsih, Sri S. et al. (2002). Kesehatan Reproduksi, Gender, dan Otonomi Daerah: Kebijakan dan Implementasi di Kota Pontianak, Kabupaten Sikka, dan Kota Cirebon. Center for Population Studies, Indonesian Institute of Sciences, *Policy Paper*; No. 53.
- Sadli, Saporinah (2010). *Berbeda Tetapi Setara, Pemikiran Tentang Kajian Perempuan* in Imelda Bachtar (ed.). Jakarta: Kompas Media Nusantara.
- World Health Organization (2003). *Comparative Evaluation of Indicators for Gender Equity and Health*. Japan: WHO Kobe Centre.
- World Health Organization (2004). *Gender, Health, and Work*. 2004, (downloaded 2016 July 15) Available from http://www.who.int/gender/other_health/Gender,HealthandWorklast.pdf